1	2	3 PATIENT CONTROL NO.	4 TYPE OF BILL				
		3	4				
	5 FED TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH	7 COV D.	8 N.CO.	9 C-ID.	10 L-R.D.	11
	5	6					

12 PATIENT NAME 12	13 PATIENT ADDRESS 13

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D JR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31
14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37 A B	37
	32		33		34		35		36			

	39 VALUE CODES CODE	AMOUNT		40 VALUE CODES CODE	AMOUNT		41 VALUE CODES CODE	AMOUNT	
a									
b									
c									
d									

42 REV. CO.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV. DATE	46 SERV UNITS	47 TOTAL CHARGES		48 NON-COVERED CHARGES		49
42	43	44	45	46	47		48		49

50 PAYER	51 PROVIDER NO.	52 REL	53 ASO	54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56
50	51	52	53	54		55		56

57		DUE FROM PATIENT

58 INSURED'S NAME	59 P. REL	60 CERT. SSN. HIC. ID NO..	61 GROUP NAME	62 INSURANCE GROUP NO.
58	59	60	61	62

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
63	64	65	66

67 PRIN.DIAG.CO.	OTHER DIAG. CODES '8 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE		76ADM.DIAG.CO.	77 E-CODE	78
67	68	69	70	71	72	73	74	75		76	77	78

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURES CODE	DATE	82 ATTENDING PHYS. ID..
79	80		81				82

84 REMARKS	83. OTHER PHYS. ID
84	83
	OTHER PHYS. ID.
	85. PROVIDER REPRESENTATIVE DATE
	X 85

FIGURE 1A

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) / CHAMPUS (Sponsor's SSN) / CHAMPVA (VA File #) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID)	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY SEX M F
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other
7. INSURED'S ADDRESS (No., Street)	
CITY / STATE	8. PATIENT STATUS Single Married Other / Employed Full-Time Student Part-Time Student
CITY / STATE	
ZIP CODE / TELEPHONE (Include Area Code) ( )	
ZIP CODE / TELEPHONE (INCLUDE AREA CODE) ( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO
a. INSURED'S DATE OF BIRTH MM DD YY SEX M F	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F	b. AUTO ACCIDENT? YES NO PLACE (State)
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES NO
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. ___ 2. ___ 3. ___ 4. ___		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. BALANCE DUE $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)		33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # PIN# GRP#		

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

FIG. 1B

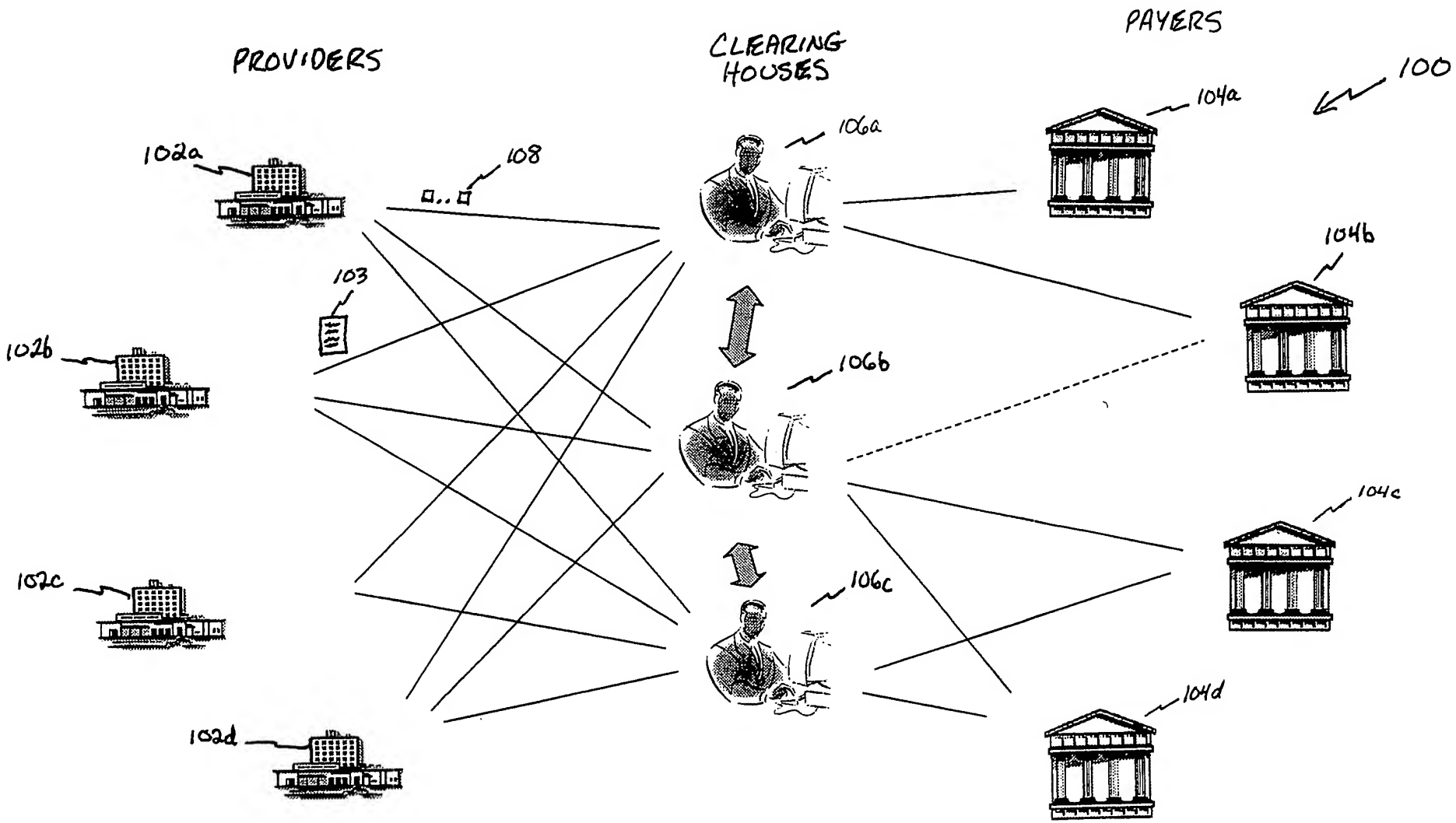
PROVIDERS
CLEARING HOUSES
PAYERS
100
102a
102b
102c
102d
103
108
106a
106b
106c
104a
104b
104c
104d

FIG. 1C

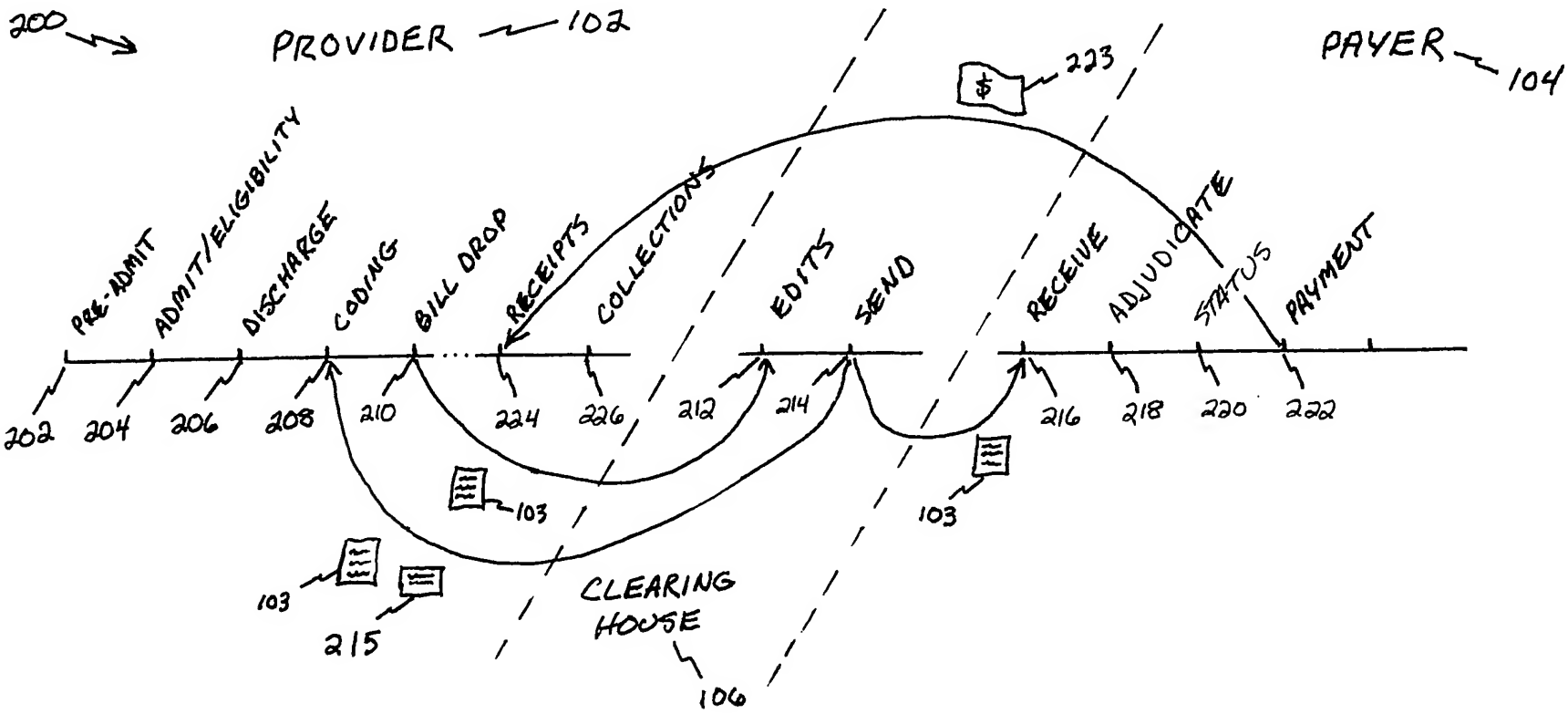
200
PROVIDER
102
PAYER
104
223
PRE-ADMIT
ADMIT/ELIGIBILITY
DISCHARGE
CODING
BILL DROP
RECEIPTS
COLLECTIONS
EDITS
SEND
RECEIVE
ADJUDICATE
STATUS
PAYMENT
202
204
206
208
210
224
226
212
214
216
218
220
222
103
103
103
215
CLEARING HOUSE
106

FIG. 2

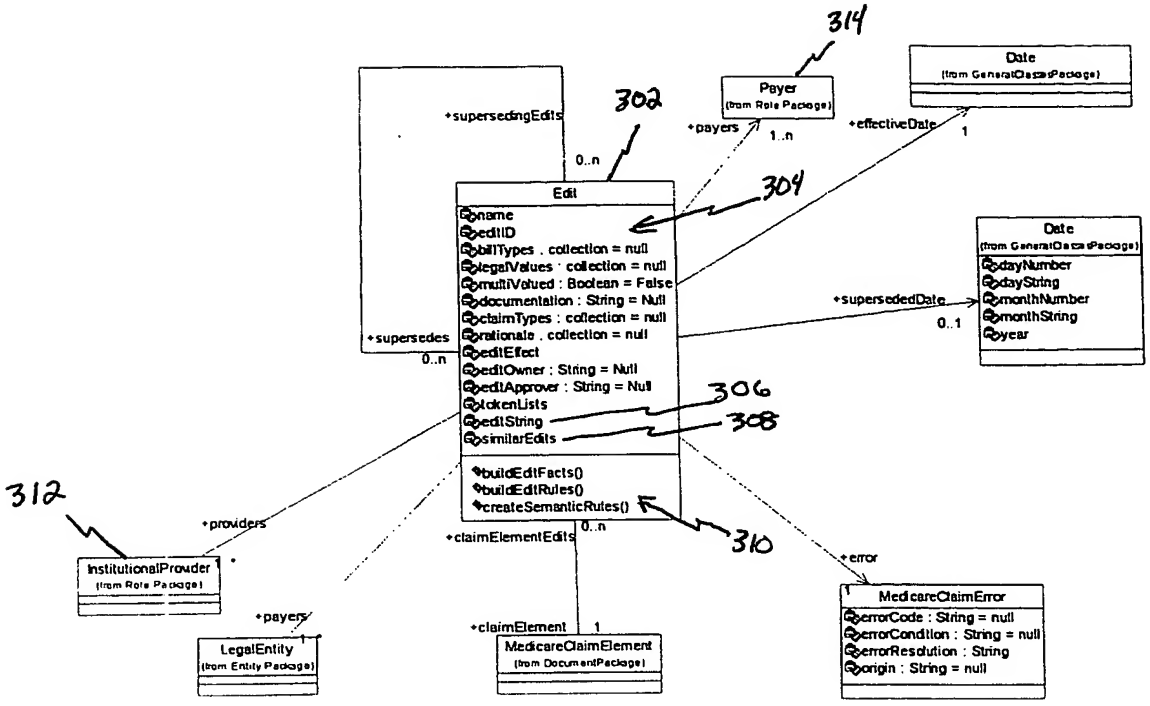

FIGURE 3

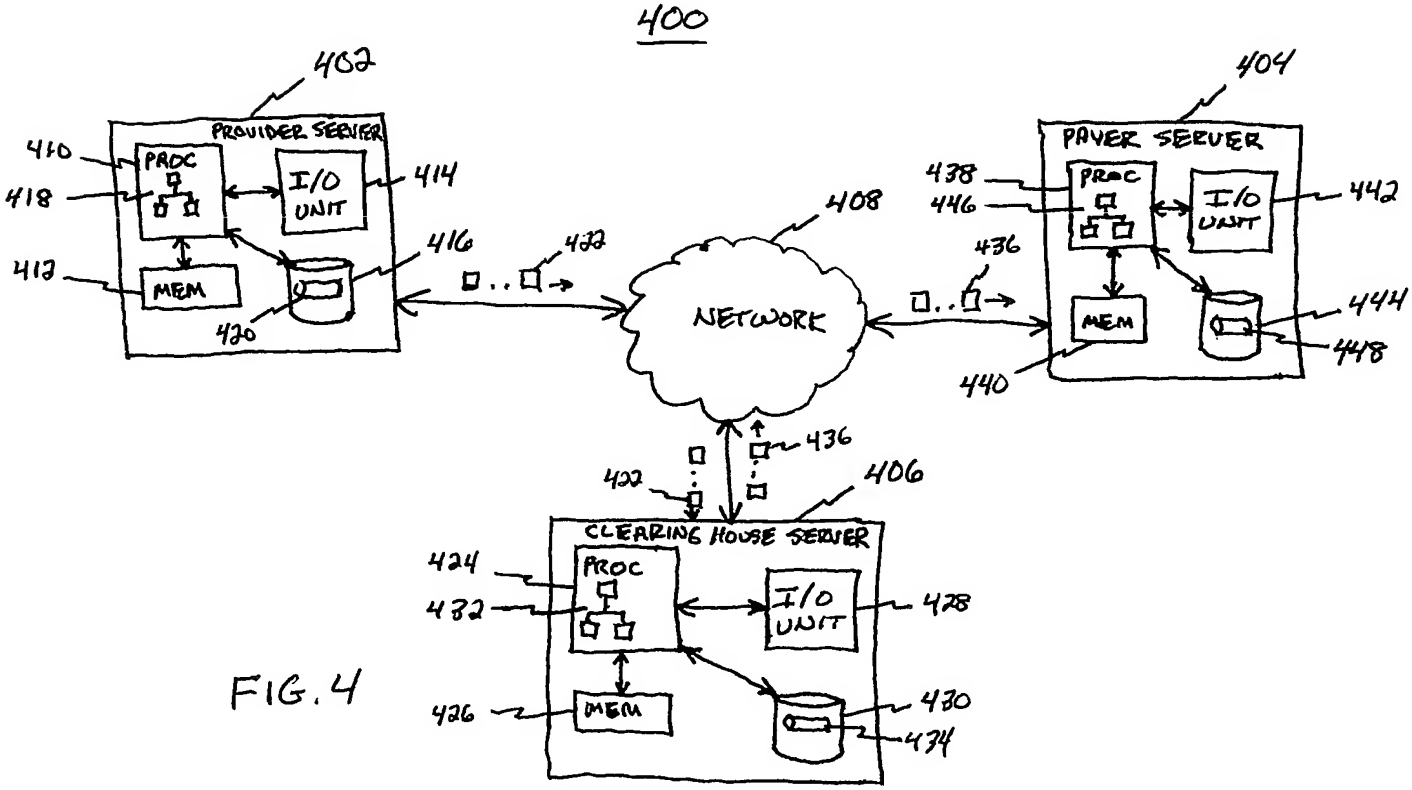

FIG. 4

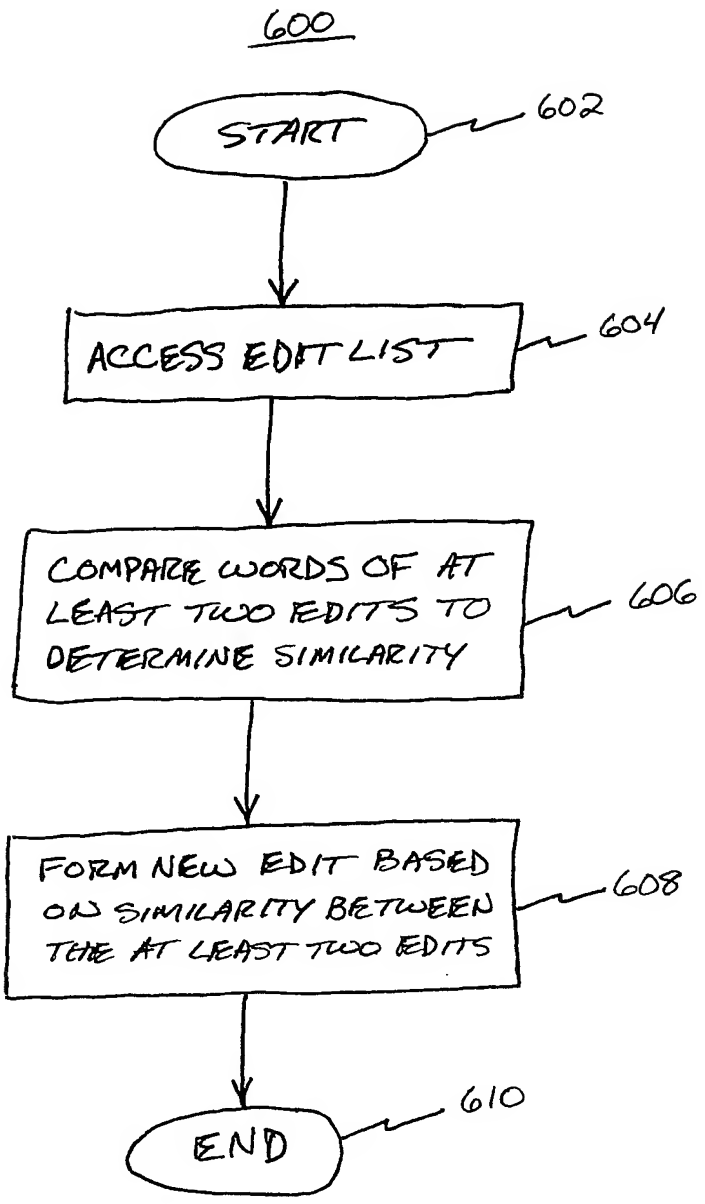
600
START
602
ACCESS EDIT LIST
604
COMPARE WORDS OF AT LEAST TWO EDITS TO DETERMINE SIMILARITY
606
FORM NEW EDIT BASED ON SIMILARITY BETWEEN THE AT LEAST TWO EDITS
608
END
610

FIG. 6

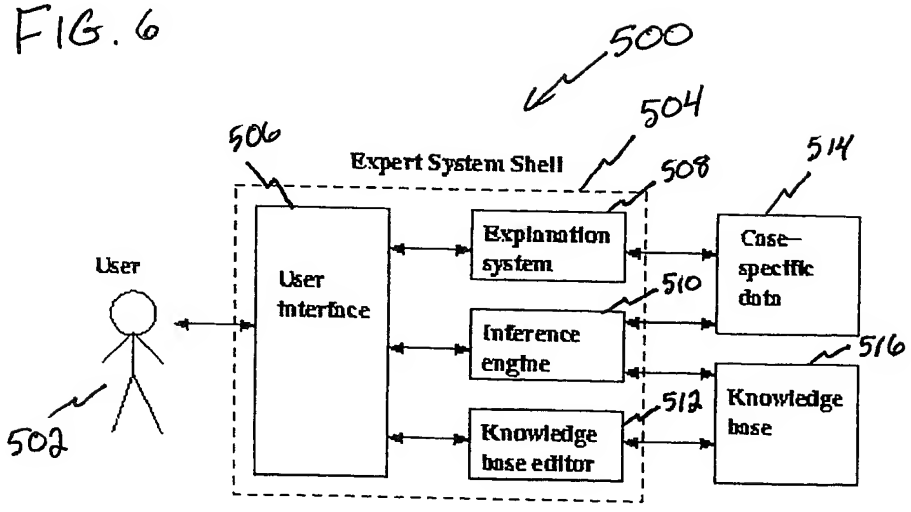
500
504
506
Expert System Shell
508
514
User
User interface
Explanation system
Case-specific data
510
Inference engine
516
Knowledge base
512
Knowledge base editor
502

FIG. 5

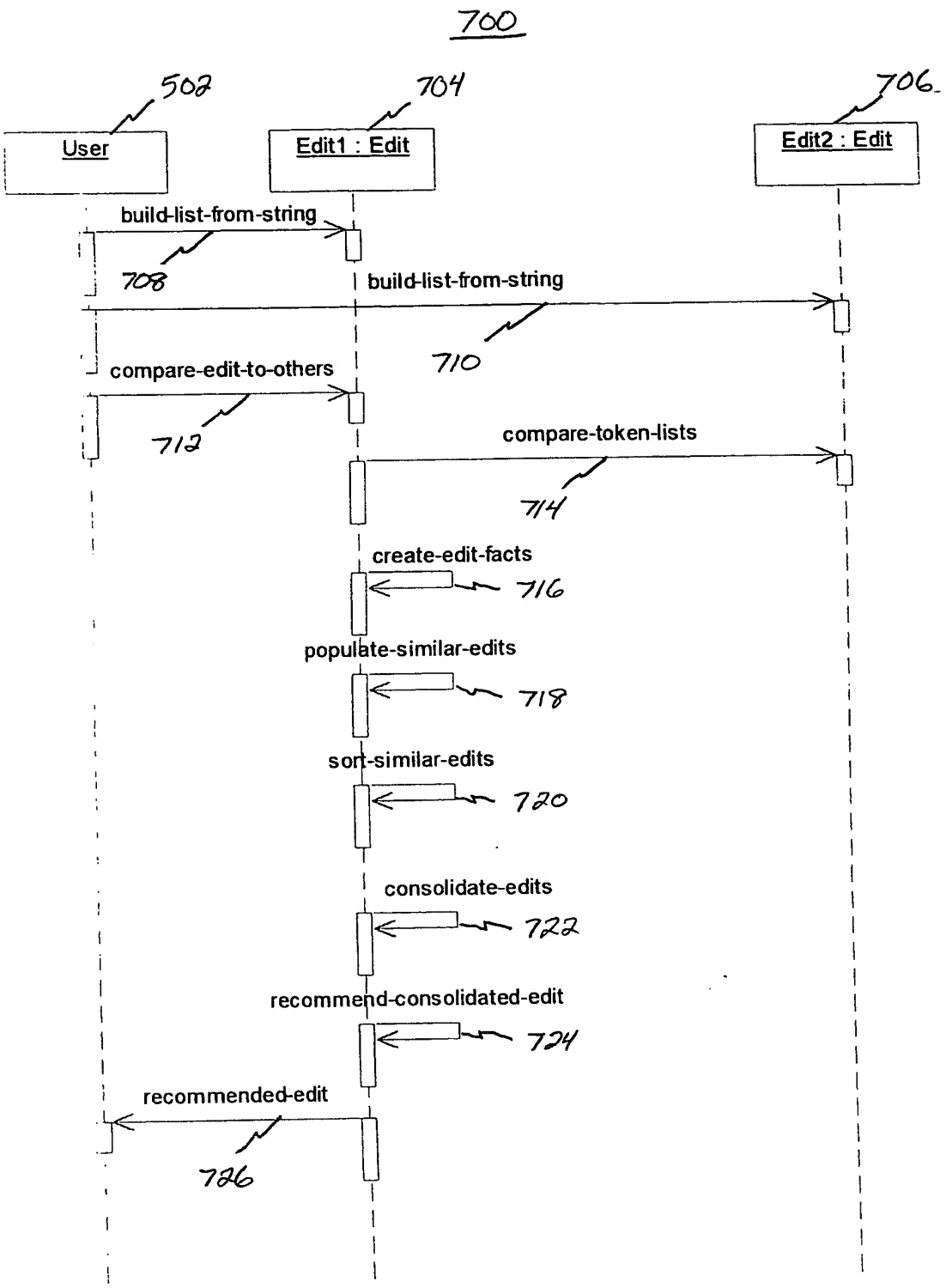
700
502
User
704
Edit1 : Edit
706
Edit2 : Edit
build-list-from-string
708
build-list-from-string
710
compare-edit-to-others
712
compare-token-lists
714
create-edit-facts
716
populate-similar-edits
718
sort-similar-edits
720
consolidate-edits
722
recommend-consolidated-edit
724
recommended-edit
726

FIGURE 7

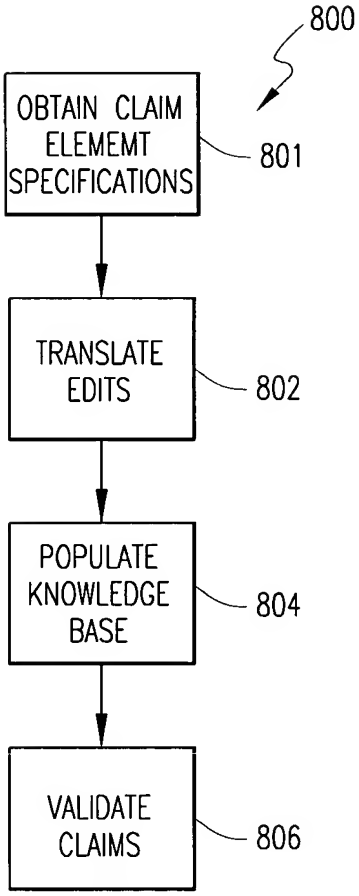
800
OBTAIN CLAIM ELEMEMT SPECIFICATIONS
801
TRANSLATE EDITS
802
POPULATE KNOWLEDGE BASE
804
VALIDATE CLAIMS
806

FIG. 8

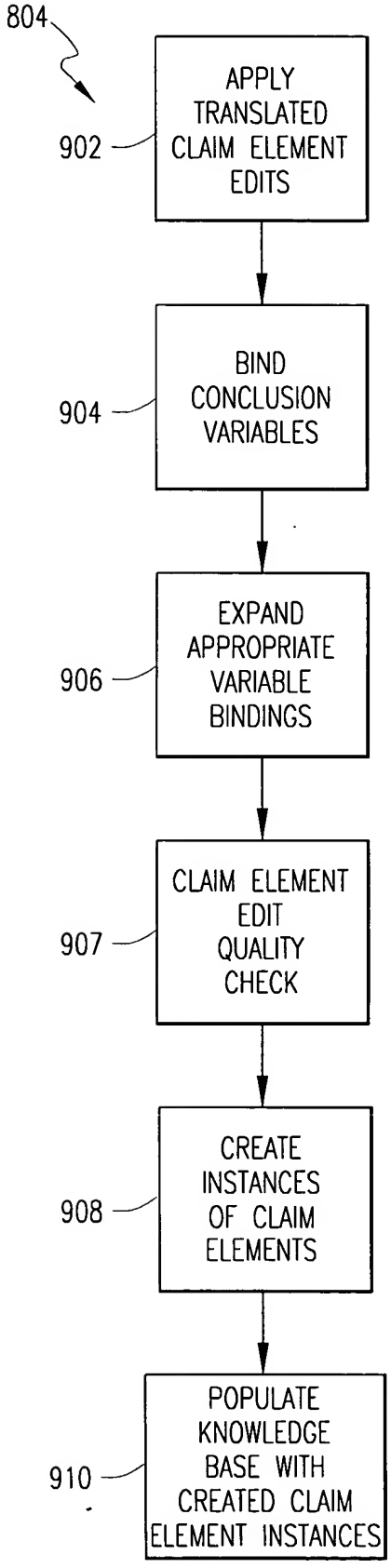
804
902
APPLY TRANSLATED CLAIM ELEMENT EDITS
904
BIND CONCLUSION VARIABLES
906
EXPAND APPROPRIATE VARIABLE BINDINGS
907
CLAIM ELEMENT EDIT QUALITY CHECK
908
CREATE INSTANCES OF CLAIM ELEMENTS
910
POPULATE KNOWLEDGE BASE WITH CREATED CLAIM ELEMENT INSTANCES

FIG. 9